

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

618 CERTIFICATE OF DEATH

00588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 6 lyr. 20das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS 14372 703 High Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Annie	Middle -	Last Akers	4. DATE OF DEATH January 21	Month January	Day 21	Year 1958		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Unknown	9. AGE (In years lost birthday) 95 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Xxx-X-0000		17. INFORMANT RECORDS ✓ Eastern Shore State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 422.1		DUE TO (b) Cirrhosis of Liver							
		DUE TO (c) Chronic Myocarditis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) H90K Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 1958		(State)	
21. I certify that I attended the deceased from April 25, 1957 , to Jan. 21, 1958 , that I last saw the deceased alive on Jan. 21, 1958 , and that death occurred at 7:30a M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chestertown, Md.							DATE SIGNED 1-21-58
ACTUAL SIGNATURE Harry J. Crawford		M.D. E.S.S. Hospital, Cambridge, Md.							
PHYSICIAN'S NAME (Type) Dr. Harry J. Crawford									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Chester Cem.		22d. LOCATION (City, town, or county) Chestertown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 23 '58			24b. REGISTRAR'S SIGNATURE W. F. Schenck		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Pgce 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 1 and 2 should be filed with the registrar prior to burial; cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

FD-246 (Rev. 1-25-50)

NAME OF DECEASED	
JAMES LEE HARRIS	
ADDRESS	
111 E. 23rd Street	
CITY, STATE, ZIP	
Baltimore, Maryland 21218	
AGE	
60 years	
SEX	
Male	
RACE	
White	
MATERIAL TESTED	
Blood	
TESTS	
Hepatitis B Surface Antigen	
Hepatitis C Virus	
HIV	
Syphilis	
Tuberculosis	
Other	
TEST RESULTS	
Hepatitis B Surface Antigen	
Hepatitis C Virus	
HIV	
Syphilis	
Tuberculosis	
Other	
TEST COMMENTS	
No evidence of Hepatitis B Surface Antigen, Hepatitis C Virus, HIV, Syphilis or Tuberculosis.	
TESTER SIGNATURE	
SARAH M. COOPER	
TESTER TITLE	
LABORATORY DIRECTOR	
TEST DATE	
JAN. 23, 1998	

BUREAU V.

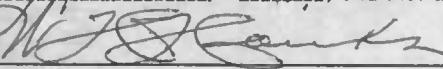
REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00589

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b -life-50 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 West End Ave.		d. STREET ADDRESS 306 West End Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First William	Middle H.	Last Applegarth	4. DATE OF DEATH Jan. 14, 1958	Month Jan.	Day 14	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/1877	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Ret.		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William L. Applegarth		14. MOTHER'S MAIDEN NAME Laura E. Hubbard						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. William Applegarth	Address 306 West End Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Central Nervous System DUE TO (c) Central Arteriosclerosis Essential Hypertension		INTERVAL BETWEEN ONSET AND DEATH 10 days.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge	(County) Charles	(State) Md.
21. I certify that I attended the deceased from 1/16/58 , 1958, to 1/14/58 , 1958, that I last saw the deceased alive on 1/14/58 , 1958, and that death occurred at 1/14/58 , 1958, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. 104 Locust Cambridge		DATE SIGNED 1/15/58		
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) W.H. Hanks						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/57		22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR LeCompte		24b. REGISTRAR'S SIGNATURE LeCompte		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

JAN 20 1968

REGELIV EO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

593

Item 9 Film G225 2-10-58 et

Reg. Dist. No.

00590

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM2. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		5. SEX		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Dorchester MARYLAND		Female Negro		Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cambridge		Life		Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
101 Pine Street		101 Pine Street			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Ida		Jane	Bazzle	Jan.	Month Day Year
5. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Negro		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 14, 1879 78 <input checked="" type="checkbox"/> yrs.	Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Housewife		Dorchester Co., Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
George Waters		Martha Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No		None		Charles Bazzle, Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY; Instant					
IMMEDIATE CAUSE (a) Coronary occlusion					
420.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (b)					
(a), stating the underlying cause lost. DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/28/58	
EXAMINER'S NAME (Type) John Mace Jr. M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/1958		22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. Stiles Jr.</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR FEB 7 '58	
				24b. REGISTRAR'S SIGNATURE <i>Albert J. Edwards</i>	
VS. A1SME 5M 2/57					

RECEIVED
BUREAU V. S.

FEB 7 1958

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH PLACE	DEATH NUMBER
JOHN H. HANSON	42	MALE	2/6/58	10:30 P.M.	HEART DISEASE	HOSPITAL	11529-58-0001
EXAMINER'S SIGNATURE							

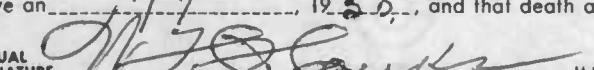
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00591

619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 1		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Albert	Middle Houston	Last Bell	4. DATE OF DEATH	Month Jan.	Day 7, 1958	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 12, 1897	9. AGE (In years from last birthday) 60	IF UNDER 1 YEAR Months 60	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Hauling self employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge, R.D.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Bell		14. MOTHER'S MAIDEN NAME Maggie Hughes					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Myrtle Bell, Cambridge, Md. R.D. 1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 hour.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chr. Diodeal ulcer.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 Locust St.	20f. (City or town) Cambridge	(County) MD.	(State) Md.	
21. I certify that I attended the deceased from alive on 1/7, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 104 Locust St.		DATE SIGNED 1/21/58	
ACTUAL SIGNATURE 	PHYSICIAN'S NAME (Type) W.H. Hanks						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 9, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park	22d. LOCATION (City, town, or county) Cambridge, Md.			(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shoumard	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR JAN 9 '58		24b. REGISTRAR'S SIGNATURE Albert			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 9 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

594

CERTIFICATE OF DEATH

Reg. Dist. No.

00592

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 8 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS Oakley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Betty		First	Middle	Last	4. DATE OF DEATH Jan. 22, 1958	Month	Day	Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1958		9. AGE (In years last birthday) yrs. 8	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours 8	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Charles E. Brohawn, Jr.		14. MOTHER'S MAIDEN NAME Elizabeth Callahan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles E. Brohawn, Jr. Oakley St., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Congenital Anomalies - Cretin		DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 1-22 , 19 58 , to 1-22 , 19 58 , that I last saw the deceased alive on 1-22 , 19 58 , and that death occurred at 10:00 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Cambridge						DATE SIGNED Jan. 23, 1958	
ACTUAL SIGNATURE Sgt. Baumann		M.D.									
PHYSICIAN'S NAME (Type) Kenneth R. Thomas											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1958		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR JAN 27 '58		24b. REGISTRAR'S SIGNATURE Asst. Director					

BUREAU V. 8

JAN 27 1953

RECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

620

CERTIFICATE OF DEATH

00593

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3		d. STREET ADDRESS RFD #3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Matilda	Middle Cornish	Last Jan 20, 1958	4. DATE OF DEATH Jan 20, 1958	Month Jan	Day 20	Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 20, 1887	9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Columbus Wheatley		14. MOTHER'S MAIDEN NAME Adeline Morris						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Ernest Cornish, RFD #3 Cambridge, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				<i>Leiomyosarcoma uterus</i>		INTERVAL BETWEEN ONSET AND DEATH 1		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1/20 , 19 58 , to 1/27 , 19 58 , that I last saw the deceased alive on 1/27 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE W.H. Hawks				ADDRESS (Street, city or town, state) 1046 Locust St. Cambridge, Md.		DATE SIGNED 1/27/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/1958		22c. NAME OF CEMETERY OR CREMATORIUM Beckwith Cemetery		22d. LOCATION (City, town, or county) RFD #3 Cambridge, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Herbert McElroy		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE FEB 7 '58		24b. REGISTRAR'S SIGNATURE Albert couch		

BUREAU V. S.

EEB 7 1953

REGELY EU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

595

CERTIFICATE OF DEATH

00594

Reg. Dist. No.

After death: Page 4
 by the funeral director.
 After this certificate has been signed by the attending physician and completed
 page 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 40 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Cambridge Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nellie	Middle M.	Last Creighton	4. DATE OF DEATH Jan. 14, 1958	Month Jan.	Day 14	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1873	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hughes				14. MOTHER'S MAIDEN NAME Elizabeth Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Amos Creighton		Address Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 3 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. -- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 14 1957 to January 14 1958 , that I last saw the deceased alive on January 14 , 1958, and that death occurred at 9:10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Eldridge H. Wolff</i> ADDRESS (Street, city or town, state) M.D. 15 Locust Street Cambridge Maryland DATE SIGNED 1-16-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/57		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE JAN 27 '58		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

CERTIFICATE OF DEATH

NAME	AGE	SEX	DEATH DATE
WILLIAM H. COOPER	60	M	JAN 27, 1968
ADDRESS			
101 E. BELLEVUE ST.			
BALTIMORE, MD 21202			
CITY, STATE, ZIP CODE			
BORN JAN 27, 1907			
DIED JAN 27, 1968			
CAUSE OF DEATH			
HEART DISEASE			
METHOD OF DEATH			
NATURAL			
TIME OF DEATH			
10:00 AM			
TIME OF REPORT			
10:30 AM			
SIGNATURE			
DR. RICHARD J. KELLY			
SIGNATURE			
DR. RICHARD J. KELLY			

BUREAU V. 2

JAN 27 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

621

CERTIFICATE OF DEATH

00595

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Talbot b. COUNTY Maryland		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton 20 x -2			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 3yr. 6mo. 9das.		d. STREET ADDRESS R.F.D.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital									
3. NAME OF DECEASED (Type or print) Lizzie		First	Middle	Last	4. DATE OF DEATH Davenport	Month	Day	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1869 ?	9. AGE (In years lost birthday) 89 ? yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown (Coby)		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT		Address RECORDS - Eastern Shore State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sev. Yrs. " "			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome Assoc. With Senile Brain Disease, With Psychosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic Brain Syndrome Assoc. With Senile Brain Disease, With Psychosis							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 19, 1954 , to January 28 1958 , that I last saw the deceased alive on January 28, 1958 , and that death occurred at 7:20 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Simon Virkutis , M.D. E.S.S. Hospital, Cambridge, Md. 1-29-58						ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr. Simon Virkutis									
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF Jan 31 1958		22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery, Hillsboro, Md.		22d. LOCATION (City, town, or county) (State) Hillsboro, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John W. Miller, M.E. Eastern Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 31 '58		24b. REGISTRAR'S SIGNATURE Deborah			

WATERLAWN STATE PARKAMENT OF HEALTH - BOSTON 18

CERTIFICATE OF DEATH

NAME	AGE	SEX	DEATH DATE	TIME	CAUSE
WILLIAM JAMES HARRIS	60	M	APRIL 30, 1958	10:00 A.M.	HEART DISEASE
ADDRESS					
WATERLAWN STATE PARKAMENT OF HEALTH - BOSTON 18					
BUREAU NO. 11					
MAY 1, 1958					
RECEIVED					

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

596

Reg. Dist. No. 00596

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 10 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lee Drive Lodgecliffe		e. STREET ADDRESS Lee Drive Cambridge Md.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) S. Owen Davis		First	Middle	Last	4. DATE OF DEATH Jan. 12, 1958	Month	Day	Year 58
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/1917	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY Ship building		11. BIRTHPLACE (State or foreign country) Marblehead, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Capt. Henry F. D. Davis USN Ret.		14. MOTHER'S MAIDEN NAME Hazel Grant		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		Address		
				16. SOCIAL SECURITY NO. 579-12-0089		17. INFORMANT Mrs. Owen Davis		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH 30 Min.		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO Coronary occlusion						
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)						
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/15/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Cemetery	22d. LOCATION (City, town, or county) Arlington		(State) Va.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR AN 20		24b. REGISTRAR'S SIGNATURE		

BUREAU U. S.

IAN 20 1958

በኢትዮጵያ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G221 1-27-58 et

00597

597

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 207 Academy St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Preston	Middle E.	Last Dean	4. DATE OF DEATH Jan. 1, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 5/17/1893	9. AGE (In years last birthday) 64 65 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 6	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Wingate Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Dean				14. MOTHER'S MAIDEN NAME Laura Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-1805		17. INFORMANT Mrs. Fred Robinson		Address Toddville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERFORATION OF SIGMOID DUE TO 153.3 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) CARCINOMA OF SIGMOID DUE TO (c) MILITARY TUBERCULOSIS OF LUNGS DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 002x							
INTERVAL BETWEEN ONSET AND DEATH 3 Days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/8 , 19 58 , to 1/11 , 19 58 , that I last saw the deceased alive on 1/11 , 19 58 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 RACE ST							
DATE SIGNED 1/15/58							
ACTUAL SIGNATURE <i>Alfred R. Maryanov</i>	M.D. 136 RACE ST						
PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV	CAMBRIDGE, MD.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/13/57	22c. NAME OF CEMETERY OR CREMATORIUM Crapo Church Cemetery		22d. LOCATION (City, town, or county) Crapo		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D. BY REGISTRAR DATE JAN 20 1958		24b. REGISTRAR'S SIGNATURE John LeCompte	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 1SM 9/55

81 390973-001 10 01 1974 00 STATE CIRCUIT

BUREAU V. S.
IAN 30 1958
MELGELEI V E O

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8. See Birth Cert. # 23992 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00598

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		e. STREET ADDRESS 319 Choptank Ave.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jerry	Middle	Last Elliott
4. DATE OF DEATH	Month Jan.	Day 13,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/54
9. AGE (In years (last birthday) 23 yrs.)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Elliott		14. MOTHER'S MAIDEN NAME Pauline Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Pauline Thomas		Address 319 Choptank Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) _____ cause undetermined			
INTERVAL BETWEEN ONSET AND DEATH CEREBRAL OEDEMA			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 46-58 , 19_____, to 1-13-58 , 19_____, that I last saw the deceased alive on 1-12-58 , 19_____, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Albert E. Bunker M.D. 200 Maryland Avenue, Cambridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/57	
22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR DATE JAN 2 1958	
ADDRESS Cambridge Md.		24b. REGISTRAR'S SIGNATURE Albert E. Bunker	

WISCONSIN STATE GOVERNMENT—BAGNOLIN, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be pinned for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 20 Film 225 2-12-58 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

599

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb 20 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sunburst Hwy.		e. STREET ADDRESS Sunburst Hwy.	
f. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Octavia		First G.	Middle Elliott
4. DATE OF DEATH Jan. 27, 1958		5. SEX Female	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/31/1873	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
10c. BIRTHPLACE (State or foreign country) Drawbridge Md.		14. MOTHER'S MAIDEN NAME Amanda Horseman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. John Rose		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Fracture neck Left Femur	
		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) DUE TO Slipped and fell in home		21 days	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell in home	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Cambridge	
		(County) Dor	
		(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr. M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		DATE SIGNED 1/29/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Vienna Cemetery		22d. LOCATION (City, town, or county) Vienna	
VS. A15ME 5M 2/57		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D. BY REGISTRAR FEB 6 1958	
		24b. REGISTRAR'S SIGNATURE W.H. Gedrich	

37674 ROL
RECORDED

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
MEDICAL EXAMINER CERTIFICATE OF DEATH

BUREAU X

EB 6 1958

MEDICAL
EXAMINER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

690

CERTIFICATE OF DEATH

00600

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filed in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md/	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 30 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 West End Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	
3. NAME OF DECEASED (Type or print) Spencer		First W.	Middle Forrest
4. DATE OF DEATH Jan. 15, 1958	Month Jan.	Day 15	Year 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/1902
9. AGE (In years last birthday) 55		10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Hollands Island, Md/		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley Forrest		14. MOTHER'S MAIDEN NAME Ella Bradshaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No Yes Coast Guard		16. SOCIAL SECURITY NO. 220-16-9502	
17. INFORMANT		Address Mrs. Spencer Forrest 123 West End Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 hrs			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-14 , 1958, to 1-15 , 1958, that I last saw the deceased alive on 1-15 , 1958, and that death occurred at 2:35 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Mr. Bannam</i>		ADDRESS (Street, city or town, state) Cambridge, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 1-18-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/17/57	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park	22d. LOCATION (City, town, or county) Cambridge
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR DATE JAN 22 '58
			24b. REGISTRAR'S SIGNATURE <i>W.L. Deuch</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00601

622 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Elwood		d. STREET ADDRESS Near Elwood				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Trenda	Middle Lee	Last Friend	4. DATE OF DEATH January 28, 1958	Month January	Day 28	Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH April 29, 1957	9. AGE (In years lost birthday) yrs. 8	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 29	Hours Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Larry Lewis Perry				14. MOTHER'S MAIDEN NAME Rosezina Friend				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Rosezina Friend, Hurlock, Maryland, R.F.D.	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (Bronch.) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH P-30g				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m. 19	Month Jan.	Day 127	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) Preston, Maryland	(State) 112918		
21. I certify that I attended the deceased from 1127 , 19 58 , to 1128 , 19 58 , that I last saw the deceased alive on 1127 , 19 58 , and that death occurred at 8:10 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Harold B. Plummer	M.D.		ADDRESS (Street, city or town, state) Preston, Maryland					
PHYSICIAN'S NAME (Type) Harold B. Plummer	DATE SIGNED 112918							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 30, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Washington Cemetery	22d. LOCATION (City, town, or county) (State) Hurlock, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 31 '58	24b. REGISTRAR'S SIGNATURE Alfred couch		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAY 31 1958

BUREAU OF

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00602

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains or prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
Dorchester		Maryland		4 years		Cambridge—Maryland Hospital									
67		13 Cambridge		111 Locust St.											
3. NAME OF DECEASED (Type or print)		First Isabelle		Middle Lewis		Last Gray		4. DATE OF DEATH	Month Jan. 8, 1958	Day	Year 19				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Female		White		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		Sept. 22, 1894	63 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Homemaker								Cambridge, R.F.D.				U.S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				Address							
Summerfield Lewis				Ida Mills				Mrs. Clyde H. Henry, Cambridge, Md. R.D. 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH 30 Min.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion															
420.1 DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
DUE TO															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
Hour a. m. p. m.		19		White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												DATE SIGNED 1/10/58			
ACTUAL SIGNATURE <i>John Mace Jr.</i>															
EXAMINER'S NAME (Type) Dr. John Mace Jr.												M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)									
Burial		Jan. 10, 1958		Dorchester Memorial Park		Cambridge, Md.									
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Shou</i>												ADDRESS Cambridge, Md.			
24a. REC'D BY REGISTRAR JAN 14 '58												24b. REGISTRAR'S SIGNATURE <i>Al. Seduch</i>			
												DATE			

MISSOURI STATE BOARD OF EQUALIZATION
MAILING DIVISION'S CERTIFICATE OF DEATH

BUREAU V. 2

JAN 14 1968

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hudson Md.		c. LENGTH OF STAY IN 1b 20 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hudson Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hudson Md.		d. STREET ADDRESS Hudson Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Daisey		First Daisey	Middle Marshall	Lost	4. DATE OF DEATH Jan. 8, 1958	Month Jan.	Doy 8	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/1878	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cason's Neck Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Marshall		14. MOTHER'S MAIDEN NAME Anna Seward		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John R. Hubbard		INTERVAL BETWEEN ONSET AND DEATH 5 Min.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1/9/58			
EXAMINER'S NAME (Type) John Mace Jr.	22b. DATE THEREOF 1/11/58	22c. NAME OF CEMETERY OR CREMATORIUM Speddens Seward	22d. LOCATION (City, town, or county) James Md.	(State)				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	24a. REC'D BY REGISTRAR James	24b. REGISTRAR'S SIGNATURE <i>W. L. Edwards</i>						
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	ADDRESS Cambridge Md.	DATE JAN 17 '58						

STATE OF NEW YORK
EXAMINER'S CERTIFICATE OF DEATH

STATE OF

DECEASED - JOHN T. GLENN

Deceased

BUREAU X-1

JAN 10 1933

SEARCHED
INDEXED
FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00604

602

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Dorchester MARYLAND		o. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Cambridge		Maryland Dorchester	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 169 Washington Street		d. STREET ADDRESS 169 Washington Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Josiah	Middle M.
4. DATE OF DEATH		Last Johns	Month Jan. Day 10 Year 1958
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 15, 1896		9. AGE (In years lost birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josiah Johns, Sr.		14. MOTHER'S MAIDEN NAME Teenie Ball,	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 217-10-8287 Address	
17. INFORMANT Hattie Johns, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH Several	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO		?	
(c) Arterio-sclerotic granuloma		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1957, to Jan. 15, 1958, that I last saw the deceased alive on Jan. 15, 1958, and that death occurred at 3 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED Jan 13, 1958	
ACTUAL SIGNATURE J. D. Thompson		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/1958	
22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE	
DATE JAN 13 '58		D. L. Clark	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31. 09.2011 14:57:18 – ПІДАВАННЯ ТВІРЧЕСЬКОГО СТИЛУ ВІДОБУЛОСЯ

JAN 16 1959

JAN 19
REFELV ECU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G225 2-24-58 et
603

00605

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Schoolhouse Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Catherine	Middle Jones	Last Month Day Year Jan. 6, 1958				
4. DATE OF DEATH	5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH Unknown Approx. 80yrs.	9. AGE (In years last birthday) 80yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John Allen	14. MOTHER'S MAIDEN NAME Mary Cephas	Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Neholma Brummell, Cambridge, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cardiac decompensation Atherosclerosis heart disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m. 19	Month July	Day 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 237 Pine Cambridge, Md.	20f. (City or town) Cambridge	(County) M.D.	(State) Maryland
21. I certify that I attended the deceased from July 1958 to 6 Jan 1958 that I last saw the deceased alive on 5 Jan 1958 , and that death occurred at M.D. 237 Pine Cambridge, Md. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 237 Pine Cambridge, Md.	DATE SIGNED 11 Jan 58		
MEDICAL CERTIFICATION ACTUAL SIGNATURE John Allen	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 1/11/1958	22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery	22d. LOCATION (City, town, or county) Cambridge, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert W. Clark Jr.	ADDRESS Cambridge, Md.			24a. REC'D BY REGISTRAR MN 20 1958	24b. REGISTRAR'S SIGNATURE John Allen		

CERTIFICATE OF DEATH

MAY 1948

DEATH

MAY 1948

FBI
BUREAU

JAN 20 1958

FBI
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00606

Reg. Dist. No.

624

1. PLACE OF DEATH a. COUNTY Dorchester Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md., Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishops Head Md.		c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bishops Head Md.		e. STREET ADDRESS Bishops Head Md.			
3. NAME OF DECEASED (Type or print) Edgar		First J.	Middle Jones		
4. DATE OF DEATH Jan. 23, 1958	Month Jan.	Day 23	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/1889		
9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood			
11. BIRTHPLACE (State or foreign country) Bishops Head Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Fallin G. Jones		14. MOTHER'S MAIDEN NAME Angenora Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-0986			
17. INFORMANT Mrs. Kathleen Abbott		Address Bishops Head Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO 169 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Lung INTERVAL BETWEEN ONSET AND DEATH 8 mos					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 01/10/1958 to 1/23/1958 , that I last saw the deceased alive on 1/13/1958 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Ho cest CAMBRIDGE MD. DATE SIGNED 1/24/58					
ACTUAL SIGNATURE W.H. Hanks		PHYSICIAN'S NAME (Type) W.H. Hanks			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/58	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park	22d. LOCATION (City, town, or county) Cambridge	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.			ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 27 '58	24b. REGISTRAR'S SIGNATURE Albert LeCompte

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Pgce 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME	AGE	SEX	DEATH DATE	TIME	CAUSE
WILLIAM H. COOPER	50	M	JAN 27, 1933	10:00 A.M.	CHLOROFORM
ADDRESS					
101 W. 1ST ST., GATESVILLE, KS.					
MATERIAL TESTED					
CHLOROFORM					
TESTED BY					
J. C. COOPER					
LABORATORY					
GATESVILLE POLICE DEPARTMENT					
RECEIVED					
BUREAU Y. L.					
JAN 27 1933					

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

625

CERTIFICATE OF DEATH

Item 9 File #225 2-1-58 et

Reg. Dist. No.

00607

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE	
Dorchester MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Ruralbridge 17 days.	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS Whitman - Maryland -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Eastern Shore State Hosp.			
3. NAME OF DECEASED (Type or print)	First Orenel	Middle Calvin	Last Jones
4. DATE OF DEATH	Month 1	Day 27	Year 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-1884 73 1/4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY AnyReson	11. BIRTHPLACE (State or foreign country) Maryland 1189	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Greensburg Jones	14. MOTHER'S MAIDEN NAME Sally Campbell	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT Family	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 <i>Chronic Myocarditis</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Geri-Arterio-sclerosis</i>			
DUE TO (c) <i>Cerebral</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH 1-10-58 1-27-58			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None			
20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour o. m. p. m. 19	Month Dec	Day 10	Year 1958
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) (State)
21. I certify that I attended the deceased from <u>1-27-58</u> to <u>1-27-58</u> that I last saw the deceased alive on <u>1-27-58</u> , and that death occurred at <u>Baltimore</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edwin Ward			
DATE SIGNED Edwin Ward			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/29/58	22c. NAME OF CEMETERY OR CREMATORIUM Clint Cemetery	22d. LOCATION (City, town, or county) Mt. Michaels Md
(State)			
23. FUNERAL DIRECTOR'S SIGNATURE H. Hamilton Harrison, Esq. Michael			
ADDRESS Md.			
24a. REC'D BY REGISTRAR JAN 31 '58	24b. REGISTRAR'S SIGNATURE Reuben		
DATE			

Supplementary

JAN 31 1958

RECEIVED
MAY 31 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

626 CERTIFICATE OF DEATH

Reg. Dist. No.

00608

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Dorchester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek		c. LENGTH OF STAY IN 1b 70 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Church Creek		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Sarah	Middle Fitzhugh	Last Jones	4. DATE OF DEATH Jan. 22, 1958	Month 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1862	9. AGE (In years lost birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Woolford, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Levin W. Fitzhugh		14. MOTHER'S MAIDEN NAME Sarah E. Linthicum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. No	17. INFORMANT Lillian J. Brummette, Church Creek, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary occlusion 1 hour			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary Heart Disease 10 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) H22 Pt.	(County) 136 Rue St.
21. I certify that I attended the deceased from _____		to _____	that I last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.		
ACTUAL SIGNATURE Lawrence Maryanov		M.D.	ADDRESS (Street, city or town, state) Cambridge, Md.		
PHYSICIAN'S NAME (Type) Lawrence Maryanov, M.D.		DATE SIGNED 1/23/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Old Trinity Cemetery	22d. LOCATION (City, town, or county) Church Creek, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Katherine R. Lewis.		ADDRESS Cambridge, Md.	24a. REC'D. BY REGISTRAR JAN 27 1958	24b. REGISTRAR'S SIGNATURE A. Steedrich	

CERTIFICATE OF DEATH

RECEIVED
BUREAU V.

JAN 27 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00609

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		627										18			
1. PLACE OF DEATH a. COUNTY		Dorchester				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rhodesdale				Unknown				c. LENGTH OF STAY IN 1b		d. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x Rhodesdale		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
Hayward		Cyrus		Joyne		s		1		1		15		1958	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years from birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
Male		Negro		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		About 1873		About 84		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Day Laborer				Farm				Accomack Co., Virginia				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
Unknown				Unknown											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
No				213-24-2476				Warren McWilliams, Rhodesdale, Md., R.F.D.							
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u></p> <p>DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)</p> <p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19</p> <p>20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p> <p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>John Mace Jr.</u> DATE SIGNED 1/16/58</p> <p>EXAMINER'S NAME (Type) John Mace Jr.</p> <p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Jan. 20, 1958 22c. NAME OF CEMETERY OR CREMATORIUM Rhodesdale Cemetery 22d. LOCATION (City, town, or county) Rhodesdale, Maryland (State)</p> <p>23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland ADDRESS 24a. REC'D BY REGISTRAR DATE JAN 22 '58 24b. REGISTRAR'S SIGNATURE <u>Alt. Search</u></p>															

MARYLAND STATE BOARD OF REVITALIZATION
MOTOR VEHICLE EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

BUREAU V. S.

JAN 22 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 40610

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge	c. LENGTH OF STAY IN 1b 3 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown ✓ 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital	d. STREET ADDRESS Route 1	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DAVID	Middle THOMAS	Last LLOYD
4. DATE OF DEATH	Month Jan.	Day 2	Year 19 58
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 4/8/84
		DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Lloyd		14. MOTHER'S MAIDEN NAME Georganna Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT		Address Eastern Shore State Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/31, 1954, to 1/2, 1958, that I last saw the deceased alive on Jan 2nd, 1958, and that death occurred at 12:25 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 1/2/58			
PHYSICIAN'S NAME (Type) Thomas J. Dredge			
22a. BURIAL, CREMATION, REMOVAL (Specify) Sunsel Jan 5/1958		22b. DATE THEREOF Jan 5/1958	
22c. NAME OF CEMETERY OR CREMATORIAL Cremation		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill, Md.		ADDRESS AN 6	
		24a. REC'D. BY REGISTRAR DATE 1958	
		24b. REGISTRAR'S SIGNATURE R. W. Kennedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		ADDRESS	
MATERIAL TESTED		TESTS	
CAUSE OF DEATH		DEATH CERTIFICATION	
EXAMINER'S SIGNATURE		APPROVING PHYSICIAN'S SIGNATURE	
BUREAU V. S.		JAN 6, 1958	
RECEIVED			

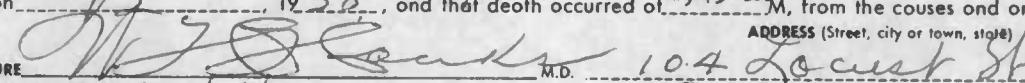
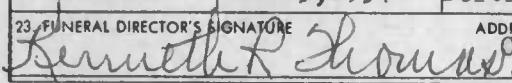
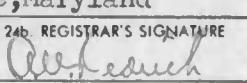
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

604

CERTIFICATE OF DEATH

00611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 212 Race St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Kenneth	Middle Paul	Last Mason	4. DATE OF DEATH	Month Jan. 3, 1958	Day	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1915	9. AGE (In years lost birthday) 42 yrs.	IF UNDER 1 YEAR Months 42	IF UNDER 24 HRS. DAYS 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Wire Cloth Mfg. Co.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ernest S. Mason			14. MOTHER'S MAIDEN NAME Cora Green				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-6926		17. INFORMANT Cora Mason, 212 Race St., Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nephroses acute							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 104 Locust St.		20f. (City or town) (County) (State) Cambridge, Maryland	
21. I certify that I attended the deceased from July 10, 1957 to 1;45 A.M. , 1958, that I last saw the deceased alive on 63 , 1958, and that death occurred at 104 Locust St. , Cambridge, Maryland, from the causes and on the date stated above.							
ACTUAL SIGNATURE 		ADDRESS (Street, city or town, state) 104 Locust St.					
PHYSICIAN'S NAME (Type) W. H. Hanks		DATE SIGNED 13/1/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 5, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JAN 7 '58		24b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 7 1963

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00612

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		605		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 50 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Timothy	Middle Mc Coy	Last	4. DATE OF DEATH	Month Jan.	Doy 27	Year 1958
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1957	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Philmore Mc Coy				14. MOTHER'S MAIDEN NAME Jessie Kane				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Jessie McCoy		Address Madison Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute gastroenteritis DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 3 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/3/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/58	22c. NAME OF CEMETERY OR CREMATORIUM Madison Cemetery		22d. LOCATION (City, town, or county) Madison			
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. St. Clair		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR FEB 7 '58			24b. REGISTRAR'S SIGNATURE <i>A. Lee</i>	
VS. A15ME SM 2/57								

4000337XV6

Two for One. FilmG225 2-7-58 et

BUREAU
FEB 7 1958
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00613

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 9mos. 4 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard		First Howard	Middle -
4. DATE OF DEATH Jan. 1.	Month Jan.	Day 1	Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-7-1890
9. AGE (In years less birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Waterman	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert McQuay		14. MOTHER'S MAIDEN NAME Josephine James.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Eastern Shore State Hospital
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		INTERVAL BETWEEN ONSET AND DEATH 4 das.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Generalized Arteriosclerosis with Heart Disease, (c)		Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X Hemoplegia right.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-28 , 19 57 , to Jan. 1 , 19 58 , that I last saw the deceased alive on Jan. 1 , 19 58 , and that death occurred at 11:00P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED		Simon Virkutis	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Simon Virkutis	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/4/58		22b. DATE THEREOF 1/4/58	22c. NAME OF CEMETERY OR CREMATORIUM Bogman
22d. LOCATION (City, town, or county) Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Norman L. Marshall - St. Michaels		24a. REC'D BY REGISTRAR DATE JAN 7 58	24b. REGISTRAR'S SIGNATURE DeLoach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

AGE AT DEATH

SEX

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DOCTOR

ADDRESS OF DOCTOR

NAME OF HOSPITAL

ADDRESS OF HOSPITAL

NAME OF FUNERAL DIRECTOR

ADDRESS OF FUNERAL DIRECTOR

NAME OF CEMETERY

ADDRESS OF CEMETERY

NAME OF ATTENDING PHYSICIAN

ADDRESS OF ATTENDING PHYSICIAN

NAME OF ASSISTANT PHYSICIAN

ADDRESS OF ASSISTANT PHYSICIAN

NAME OF ATTENDING NURSE

ADDRESS OF ATTENDING NURSE

NAME OF ASSISTANT NURSE

ADDRESS OF ASSISTANT NURSE

NAME OF LABORATORY

ADDRESS OF LABORATORY

NAME OF PATHOLOGIST

ADDRESS OF PATHOLOGIST

NAME OF ATTENDING NURSE

ADDRESS OF ATTENDING NURSE

NAME OF ASSISTANT NURSE

ADDRESS OF ASSISTANT NURSE

BUREAU V. S.

JAN 7 1959

RECEIVED

1
3
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00614

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		606 Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL)		Cambridge		c. LENGTH OF STAY IN 1b 10 yrs.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Cambridge Hospital		e. STREET ADDRESS 37 1410 Henry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Amos	Middle A. Meredith	Lost	4. DATE OF DEATH Jan.	Month 20	Doy 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/09		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Mechanic, Auto Garage		11. BIRTHPLACE (State or foreign country) Somerset Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elva Meredith		14. MOTHER'S MAIDEN NAME Sadie Hurley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, if known) No		16. SOCIAL SECURITY NO. 212-18-6467		17. INFORMANT Amos R. Meredith		Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH 20 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr.		<i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/20/58	
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan 23 1958		22c. NAME OF CEMETERY OR CREMATORIUM Sunny Ridge		22d. LOCATION (City, town, or county) Criefield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Harvey Bradshaw, Criefield, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 28 '58		24b. REGISTRAR'S SIGNATURE <i>Q. A. Smith</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 09 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

630

CERTIFICATE OF DEATH

00615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 yr. 1 mo. 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS 735 East Church St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Florence	Last Morris
4. DATE OF DEATH January 13 1958	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1893 Aug. 7, 1893
			9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland Powellville
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli P. Jones		14. MOTHER'S MAIDEN NAME Clarissa Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	17. INFORMANT Mr. Arthur G. Morris ^{Wife} (Husband) 202 East St., Delmar, Maryland RECORDS: Eastern Shore State Hospital
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		INTERVAL BETWEEN ONSET AND DEATH —	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis			
DUE TO (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-27, 1956, to 1-13, 1958, that I last saw the deceased alive on 1-13, 1958, and that death occurred at 1:20 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Simon Virkutis M.D. DATE SIGNED 1-13-58	
ACTUAL SIGNATURE <i>Simon Virkutis</i>		PHYSICIAN'S NAME (Type) Simon Virkutis	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15, 1958	22c. NAME OF CEMETERY OR CREMATORIUM St Johns Cemetery
22d. LOCATION (City, town, or county) Powellville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE JAN 14 '58	24b. REGISTRAR'S SIGNATURE <i>Dee L. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH-SAFETY

CERTIFICATE OF DEATH

NAME	AGE	SEX	DEATH DATE	TIME	CAUSE	DEATH CERTIFIED	DOCTOR	ADDRESS
CERTIFICATE OF DEATH								
WISCONSIN STATE DEPARTMENT OF HEALTH-SAFETY								
RECEIVED								

BUREAU V. A.

JAN 14 1963

RECEIVED

1
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00616

607

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 419 High St		e. STREET ADDRESS 419 High St.	
3. NAME OF DECEASED (Type or print) Gladys First Smith Middle Murray		4. DATE OF DEATH Jan. Month Doy Year 31 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 1, 1915	9. AGE (In years last birthday) 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Vernon Hamilton Sr.		14. MOTHER'S MAIDEN NAME Eva Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs Eva Smith Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 30 Min.			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/3/58
EXAMINER'S NAME (Type) Dr. John Mace Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/3/58	22c. NAME OF CEMETERY OR CREMATORIUM Beckwith Cemetery	22d. LOCATION (City, town, or county) Beckwith Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. StClair	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR FEB 7 '58	24b. REGISTRAR'S SIGNATURE <i>Albert Cauch</i>
VS. A15ME 5M 2/57			

MANHATTAN STATE EXAMINER'S OFFICE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATES
OF NEW YORK

BUREAU X-5

FEB 7 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00617

1. PLACE OF DEATH a. COUNTY		608		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission)	
<i>Dorchester</i>		MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Cambridge</i>		<i>1 yr</i>		<i>East New Market</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Glenburn Convalescent Home</i>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
<i>Amelia Steinman Patten</i>					Month Day Year
SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years from birthday) yrs.
<i>Female</i>		<i>White</i>	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>4/3/1877</i>	<input type="checkbox"/> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>None</i>		<i>none</i>		<i>Pennsylvania</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>Andrew Steinman</i>		<i>Anna (don't know)</i>		<i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<i>No</i>				<i>J. E. Patten Cambridge, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i>		<i>Cerebral Hemorrhage</i> 6 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Generalized Arteritis</i>		10 yrs			
(c) DUE TO <i>Aleuria</i>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
<i>No</i>		<i>none</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>Jan 22</i> 1958 p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>	
20f. (City or town) <i>Cambridge</i>		(County) <i>Caroline Co.</i>		(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Jan 22 1958</i> , to <i>Jan 28 1958</i> , that I last saw the deceased alive on <i>Jan 29 1958</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.					
ADDRESS (Street, City or town, state) <i>144 Race St Cambridge, Md.</i>					
DATE SIGNED <i>1-30-58</i>					
ACTUAL SIGNATURE <i>GILBERT E. MEETINS</i>					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 31/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Northwood</i>	
22d. LOCATION (City, town or County) <i>Philadelphia Pa</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Luth S. Willoughby, East New Market, Md.</i>		ADDRESS <i>15th & Willowby, East New Market, Md.</i>		24a. REC'D BY REGISTRAR <i>REC'D</i>	
				24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

DEPARTMENT OF STATE GOVERNMENT OF NEVADA - SALINOWIE 18
CERTIFICATE OF DEATH

BUREAU V.S.

EEB 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

631

CERTIFICATE OF DEATH

Reg. Dist. No.

00618

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 35 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Race St. Extd.		d. STREET ADDRESS Race St.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle E.	Last Paul	4. DATE OF DEATH Month Jan.	Day 1,	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/1871	9. AGE (In years lost, birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Dorchester Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matthew Paul			14. MOTHER'S MAIDEN NAME Jane Mc Collister				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. William Paul		Address Cambridge RFD # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident INTERVAL BETWEEN ONSET AND DEATH 442X DUE TO renal disease 5 mins. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic hypertensive cardio vascular DUE TO 2 yrs.+ (c) Arterio sclerosis and arteriolar sclerosis DUE TO 2 yrs.+							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? --- --- YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --- ---					
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- 19 p. m. --		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- ---		20f. (City or town) (County) (State) --- ---	
21. I certify that I attended the deceased from 9-2- , 19 57 , to 1-1- , 19 58 that I last saw the deceased alive on 12-31 , 19 57 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eldridge H. Wolff M.D. 15 Locust Street, Cambridge, Md. 1-2-58							
ACTUAL SIGNATURE Eldridge H. Wolff		PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/57		22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery		22d. LOCATION (City, town, or county) Cambridge (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.					
		24a. REC'D BY REGISTRAR DATE JAN 7 '58					
		24b. REGISTRAR'S SIGNATURE W. LeCompte					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

卷之二

KEGELIVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00619

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Vienna - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS RFD. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Viola		First	Middle	Lost	4. DATE OF DEATH Pinkett
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/22/1900	Month January Day 31, 1958 Year
9. AGE (In years from birthday) 57 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Josiah Collins		14. MOTHER'S MAIDEN NAME Henrietta Baltimore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Thomas R. Pinkett, Vienna, Md. RFD. #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Coronary occlusion		Address INTERVAL BETWEEN ONSET AND DEATH 5 min.	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Mace Jr.</i>	EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 2/3/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/2/58	22c. NAME OF CEMETERY OR CREMATORIUM Thompsonstown Cemetery	22d. LOCATION (City, town, or county) Near East New Market, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton & Son, Federalsburg, Md.	ADDRESS	24a. REC'D BY REGISTRAR FEB 6 '58	24b. REGISTRAR'S SIGNATURE <i>J.L. Bedell</i>		
VS. A15ME SM 2/57					

BUREAU K-1

FEB 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

632

CERTIFICATE OF DEATH

00620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Secretary Md.		c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Secretary Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Merrick's Convalescent Home		d. STREET ADDRESS Secretary Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Joseph	Middle H.	Last Rathel	4. DATE OF DEATH Jan. 12,	Month 19	Day 578	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Talbot Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Rathel			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Otis Collision		Address Cambridge Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic CVD</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Arterio - sclerotic generalized</i> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1950 , to Jan 12, 1958 , that I last saw the deceased alive on Dec 10, 1957 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED Jan 16, 1958								
ACTUAL SIGNATURE <i>W. Thompson</i> M.D.								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/58		22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE Jan 20, 1958		
						24b. REGISTRAR'S SIGNATURE <i>LeCompte</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

87 ЭРСИТАУА-БАДЫНЫ ТҮВӨНӨСҮҮК СТАЦИЯДЫГЫ

1959 00 N.Y.

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00621

633

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb CHESTERFIELD 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		17X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS —		d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mattie	Middle Hatten	Last Reynolds	4. DATE OF DEATH	Month January	Day 7	Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5-15-83	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —	Hours —		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Muterspaw				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT RECORDS: Eastern Shore State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Cardiac failure INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis — DUE TO (c) General Arteriosclerosis —									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Doy. —	Year —	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from July 8, 1957 , to January 7, 1958 , that I last saw the deceased alive on January 7, 1958 , and that death occurred at 4 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ettore DeFilippis</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Ettore DeFilippis DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/10/58	22c. NAME OF CEMETERY OR CREMATORIUM Chesterfield Cemetery			22d. LOCATION (City, town, or county) Chestertown, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE JAN 9 '58			24b. REGISTRAR'S SIGNATURE <i>G. L. Smith</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT OF HENRY - BIRMINGHAM

CERTIFICATE OF DEATH

BUREAU V.

JAN 9 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00622

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		Dorchester	
Cambridge		42 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hurlock	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Cambridge Maryland Hospital		d. STREET ADDRESS		None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Patricia	Middle Ann	Last Rivers	4. DATE OF DEATH	January	Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
female		colored		Dec. 21, 1957	0	Months 1	Day 10 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
none		-----		Cambridge, Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Jimmy Lee Glover		Daisy Mae Rivers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		-----		Records, Cambridge Maryland Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hyaline Membrane Disease				2	
773.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Prematurity - 34 weeks				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from		Dec. 21	to Jan. 31	1958	that I last saw the deceased alive on Jan. 31, 1958, and that death occurred at 8:40 P.M.	ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		Eldridge H. Wolff		M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type)		Dr. Eldridge H. Wolff		15 Locust St., Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	
Burial		Feb. 4, 1958		Washington Cemetery		Hurlock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
J.J. Frampton and Son, Federalsburg, Maryland				FEB 6 1958		J.W. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEb 6 1958

BUREAU Y. S.

THE GENEVA

00623

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1		611									
FOR STATE HEALTH DEPT.		1. PLACE OF DEATH a. COUNTY Dorchester Co.					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.				
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 302 Academy St.		
4 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 302 Academy St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
		3. NAME OF DECEASED (Type or print)		First F.	Middle Harvey	Last Rumbley	4. DATE OF DEATH	Month Jan.	Day 26,	Year 1958	IF UNDER 1 YEAR
5. SEX		6. COLOR OR RACE Male	White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/1900	9. AGE (In years from birthday) 57 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10b. KIND OF BUSINESS OR INDUSTRY Ship Repair			11. BIRTHPLACE (State or foreign country) Dorchester Co.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Rumbley					14. MOTHER'S MAIDEN NAME Lillie Slacum						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.			17. INFORMANT		Address Mrs. Howard Gray Seaford Del.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 420.1 10 min.											
DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/27/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service						24a. REC'D BY REGISTRAR DATE JAN 29 '58		24b. REGISTRAR'S SIGNATURE <i>W. J. Edean</i>			

V.S. A15ME
5M 2/57

BUREAU V. S

JAN 29 1958

RECEIVED

FOR STATE
HEALTH DEPT.

~~TO DEPUTY MEDICAL EXAMINER:~~ This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be forwarded to the Chief Medical Examiner's Office along with farm PM3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

634

Item 14 Film#224 1-20-58 et

00624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock	c. LENGTH OF STAY IN 1b All life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hurlock	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Harry	Middle Blades	Last Smith	4. DATE OF DEATH Month January	Day 4	Year 19 58
----------------------------------------	----------------	------------------	---------------	--------------------------------------	----------	---------------

5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/13/99	9. AGE (In years, last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
----------------	-----------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------	---------------------------------------------	-----------------------------------	-----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Can plant	10b. KIND OF BUSINESS OR INDUSTRY Can mfg.	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---------------------------------------------------------------------------------------------------------------	-----------------------------------------------	-------------------------------------------------------	----------------------------------------

13. FATHER'S NAME Clarence Smith	14. MOTHER'S MAIDEN NAME Minnie Blades		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Harry Smith	Address Hurlock, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 5 Min.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		
(c) DUE TO		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-----------------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------------------------------------------------

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--	--

ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 1/5/58
------------------------------------------	------------------------------------------------------	-----------------------

EXAMINER'S NAME (Type) John Mace Jr.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
-----------------------------------------	-----------------------------------------------------

22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 1/15/58	22b. DATE THEREOF 1/15/58	22c. NAME OF CEMETERY OR CREAMATORY Washington	22d. LOCATION (City, town, or county) Hurlock, Md
-------------------------------------------------------------------	------------------------------	---------------------------------------------------	------------------------------------------------------

23. FUNERAL DIRECTOR'S SIGNATURE <i>Keith S. Hollingshead</i>	ADDRESS E. J. M. M.	24a. REC'D BY REGISTRAR DATE JAN 14 '58	24b. REGISTRAR'S SIGNATURE A. W. French
------------------------------------------------------------------	------------------------	--------------------------------------------	--------------------------------------------

BUREAU V.

JAN 14 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

612

CERTIFICATE OF DEATH

00625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Two Yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 218 Cedar Street		13 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
3. NAME OF DECEASED (Type or print) Olive		First Olive	Middle Webb			
Last Stanley		4. DATE OF DEATH Jan. 22 1958	Month Day Year			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1886			
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Odessa Delaware			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Emory Webb				
14. MOTHER'S MAIDEN NAME Mary Parker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. -----		17. INFORMANT George Stanley, Cambridge, Md.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Hemiplegia, right DUE TO renal disease (c) Arteriosclerotic hypertensive cardio vascular DUE TO none		INTERVAL BETWEEN ONSET AND DEATH 3 days				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----				
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- 19 p. m. --		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----
21. I certify that I attended the deceased from 9-10-57 , 19 ----- , to 1-22-58 , 19 ----- , that I last saw the deceased alive on 1-20-58 , 19 ----- , and that death occurred at ----- , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) -----						
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>	DATE SIGNED 1-24-58					
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/27/1958	22c. NAME OF CEMETERY OR CREMATORIUM Salem Cemetery	22d. LOCATION (City, town, or county) Salem, Dor. Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter McLean Jr.</i>		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR FEB 7 '58	24b. REGISTRAR'S SIGNATURE <i>John Leach</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 ЗНОМІС-ІЛАНДІЯ ПРИДАЄ ВІДОВЛІВАННІ

BUREAU V. S.

FEB 7 1959

REGEIY EO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 11, 12, 13, 14 Film G225 2-24-58 et

635

CERTIFICATE OF DEATH

00627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES		First ALONZO	Middle THOMASON
4. DATE OF DEATH JANUARY 31 1958		Month JANUARY	Day 31
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-28-78		9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Henry Co., Virginia		12. IF UNDER 24 HRS. Days 0	13. CITIZEN OF WHAT COUNTRY? U.S.A.
14. FATHER'S NAME James Shumase		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		17. SOCIAL SECURITY NO. 18. INFORMANT EASTERN SHORE STATE HOSPITAL RECORDS.	
19. MEDICAL CERTIFICATION		Address	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		21. I certify that I last saw the deceased alive on _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 4-58	22c. NAME OF CEMETERY, OR CREMATORIAL Warren Cemetery
22d. LOCATION (City, town, or county) Roanoke, Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph Reid Rising Sun Md.		24a. REC'D BY REGISTRAR DATE FEB 3 1958	24b. REGISTRAR'S SIGNATURE W. L. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be refiled by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

E3

CHASER

BUREAU V. S.

E3 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00628

613

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Luther	Middle Henry	Last Thompson	4. DATE OF DEATH	Month January	Day 10	Year 1958		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH January 13, 1882	9. AGE (In years lost/birthday yrs.) 75	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY American Cannery		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas H. Thompson				14. MOTHER'S MAIDEN NAME Margaret A. Teakle					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 218-10-1589		17. INFORMANT Daniel A. Thompson, East New Market, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Arteriosclerotic hepatitis (b) DUE TO Coronary Heart Disease (c)						INTERVAL BETWEEN ONSET AND DEATH 3 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 136 Race St.		(County) Cambridge, Md. (State) Md.	
21. I certify that I attended the deceased from 12/28 , 19 57 to 1/10 , 19 58 , that I last saw the deceased alive on 1/10/58 , 19 58 , and that death occurred at 8:45P M , from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov		ADDRESS (Street, city or town, state) 136 Race St.							DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14, 1958		22c. NAME OF CEMETERY OR CREMATORIUM East New Market Cemetery		22d. LOCATION (City, town, or county) East New Market, Maryland		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		24e. REC'D BY REGISTRAR DATE JAN 15 '58		24b. REGISTRAR'S SIGNATURE John L. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

Date of Birth

Name of Deceased
John W. SmithAddress of Deceased
123 Main Street, Baltimore, MarylandCause of Death
Natural deathDate of Death
12/31/1950Place of Death
HomeName of Physician
Dr. John W. SmithName of Hospital
St. Mary's HospitalName of Mortician
John W. SmithName of Cemetery
Baltimore CemeteryName of Funeral Home
John W. SmithName of Embalmer
John W. SmithName of Coffin Manufacturer
John W. SmithName of Casket Manufacturer
John W. SmithName of Linen Manufacturer
John W. SmithName of Jewelry Manufacturer
John W. SmithName of Flower Manufacturer
John W. SmithName of Stationery Manufacturer
John W. SmithName of Cloth Manufacturer
John W. SmithName of Linen Manufacturer
John W. SmithName of Jewelry Manufacturer
John W. SmithName of Flower Manufacturer
John W. SmithName of Hospital
St. Mary's HospitalAddress of Hospital
123 Main Street, Baltimore, MarylandCause of Death
Natural deathDate of Death
12/31/1950Place of Death
HomeName of Physician
Dr. John W. SmithName of Hospital
St. Mary's HospitalName of Mortician
John W. SmithName of Cemetery
Baltimore CemeteryName of Funeral Home
John W. SmithName of Embalmer
John W. SmithName of Coffin Manufacturer
John W. SmithName of Casket Manufacturer
John W. SmithName of Linen Manufacturer
John W. SmithName of Jewelry Manufacturer
John W. SmithName of Stationery Manufacturer
John W. SmithName of Cloth Manufacturer
John W. SmithName of Linen Manufacturer
John W. SmithName of Jewelry Manufacturer
John W. SmithName of Flower Manufacturer
John W. SmithName of Stationery Manufacturer
John W. Smith

BUREAU V. S.

JAN 15 1963

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

614 CERTIFICATE OF DEATH

00626

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. — Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 28 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 6 Pleasant Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				d. STREET ADDRESS 6 Pleasant Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lena		First	Middle	Lost	4. DATE OF DEATH Jan. 30, 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wicomico Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME James Williams		14. MOTHER'S MAIDEN NAME Sarah Ryall						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louise Winters, Church Creek, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		DUE TO Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO 498x		4				
(c)		Senile psychosis.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 498x		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Debute Bunker				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED Hour a. m. 19 While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) Wicomico Co. (State) Md.
21. I certify that I attended the deceased from 10-11- , 19 54 to 1-30- , 19 58 , that I last saw the deceased alive on 1-30- , 19 58 , and that death occurred at 10:00 A.M. from the causes and on the date stated above. Albert E. Bunker M.D. 200 Maryland Ave.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE Bernard R. Sherman		PHYSICIAN'S NAME (Type) Albert E. Bunker		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md.		(State) Md.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 31, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bernard R. Sherman		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR FEB 3 '58		24b. REGISTRAR'S SIGNATURE Allie Reich		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

615

CERTIFICATE OF DEATH

00629

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home		e. STREET ADDRESS 702 Maryland Ave.		f. DATE OF DEATH Jan. 15, 1958		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ida V. Eichelberger Waddey		First	Middle	Last	Month	Day	Year		
4. SEX Female		5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1876	9. AGE (In years lost birthday) 81 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles E. Eichelberger		14. MOTHER'S MAIDEN NAME Louise Horpel							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. James C. Garing, Sr., 702 Maryland Ave., Camb., Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction						6 hrs.			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic cardio vascular renal disease						10 yrs.+			
(b) DUE TO Arteriosclerosis, generalized						10 yrs.+			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- 19 p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) ---	(County) ---	(State) ---	
21. I certify that I attended the deceased from 9-4-57 , 19, to 1-15-58 , 19, that I last saw the deceased alive on 1-15-58 , 19, and that death occurred at 7:45 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Maryland			DATE SIGNED 1-16-58
ACTUAL SIGNATURE Eldridge H. Wolff		M.D.							
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 18, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Meadow Ridge Cemetery		22d. LOCATION (City, town, or county) Elkridge, Baltimore, Md.		(State) Md.	
23. KENNETH R. THOMAS, Kennele R. Thomas, Wm. J. Tickner & Sons, Baltimore,		ADDRESS Cambridge, Maryland.		24a. REC'D. BY REGISTRAR JAN 20 '58		24b. REGISTRAR'S SIGNATURE Alfred			

BE DEDICATED TO THE UNITED STATES OF AMERICA

JAN 20 1958

BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

616

CERTIFICATE OF DEATH

Reg. Dist. No.

00630

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS 532 Leonards Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle W.	Last Willey Sr.	4. DATE OF DEATH	Month Jan.	Day 20,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12/19/1892	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Food Processing		11. BIRTHPLACE (State or foreign country) Seward Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Willey				14. MOTHER'S MAIDEN NAME Elnora Insley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Nellie Bramble Willey 532 Leonards La.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 days under							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ADDRESS (Street, city or town, state) 136 RACE ST CAMBRIDGE, MD.	(County)	(State)
21. I certify that I attended the deceased from 8/25/1958 , to 1/19/1958 , that I last saw the deceased alive on 1/19/1958 , and that death occurred at 11 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Alfred R. Maryanov M.D. DATE SIGNED 1/21/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/58		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE JAN 27 '58	
VS A15 (4) 1SM 9/55						24b. REGISTRAR'S SIGNATURE W. J. Deacon	

ВІД ДІМОНІЗАВ-ІНГДІАН ТО ТІМПЛІАЧІ ВІДЕО ГІДАЧУПАКІ

BUREAU V. S.

JAN 27 1959

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

617

CERTIFICATE OF DEATH

Reg. Dist. No.

00631

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS 1 205 Byron St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Melvin	Middle 	Last Willey	4. DATE OF DEATH Jan. 20, 1958	Month Jan.	Day 20	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Macintire Willey				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Harry Mowbray		Address 205 Byron St. Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-3- , 19 45 , to 1-20- , 19 58 , that I last saw the deceased alive on 1-30-1948 , and that death occurred at 12-8 M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Albert E. Bunker M.D. 200 Maryland Avenue DATE SIGNED Albert E. Bunker							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) Albert E. Bunker Cambridge - Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/58		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LeCompte Funeral Service Cambridge Md.				24a. REC'D BY REGISTRAR DATE JAN 29 '58 Albert E. Bunker REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15 HAWAIIAN STATE LAND SURVEYOR'S REPORT

BUREAU V.

JAN 29 1959

REGELY ED